saaac South Australian Abortion Action Coalition

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South Australian Law Reform Institute
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SUBMISSION - REFORM OF SA ABORTION LAWS

Executive Summary

The South Australian Abortion Action Coalition (***saaac***) is a community coalition formed in 2016 with the aim of improving access to abortion. *saaac* is a broad coalition of people with backgrounds in health, law, women's services, unions, academia and community activism who support the removal of the regulation of abortion practices and services from the criminal law.

saaac recognises that abortion remains a stigmatised procedure in health care and advocate for its regulation like all other health care not only to enable better access but to encourage its social position to that of all other urgent health care procedures; an essential service with provision based on the best quality evidence available.

People needing abortions are referred to in this submission as women and the vast majority of abortions are provided to people who identify as women. *saaac* acknowledges that other people who do not identify as women can need access to abortion.

Trans-men, gender queer and others of diverse gender identities who do not necessarily identify as women, can and do get pregnant and require abortion care.

Legislative reform is an opportunity to remove the legislative stigmatisation of abortion. While the impact of such a move is difficult to measure there is no doubt that the normalisation of this health procedure can create an environment for provision that can better meet the challenges in accessing safe abortion information and services.

The regulation of abortion by criminal law creates barriers for women and service providers when accessing and providing contemporary best practice health care. Health care and technologies have changed since the South Australian law was put in place in 1969 and our outdated laws are restricting women's, particularly rural women's, access to this essential health care service.

The following features of the current law create significant barriers for South Australian women:

- That abortions must be performed in a prescribed hospital;
- That two (2) doctors must examine the woman and certify that she meets the legally specified criteria;
- That there is a 28 week upper gestational limit but the child destruction clause makes for an uncertain gestation limit; and
- That there is a 2-month residency requirement.

The current law creates particular barriers for rural and remote women accessing abortion services. The hospital requirement and the two doctor requirement can be hard to meet in rural and remote locations. As a consequence nearly 9 out of 10 rural women have to travel to metropolitan Adelaide because they cannot access abortion care from their local doctor or by telemedicine. Aboriginal women are disproportionately resident in rural and remote locations and so disproportionately affected.

Early Medication Abortion (**EMA**) with mifepristone (RU486) and misoprostol has been widely available in Australia since 2013 as an alternative to surgical abortion for pregnancies less than 9 weeks' gestation. The provision of EMA by telemedicine and/or local primary health care services, as is the case in every other jurisdiction in Australia, could improve accessibility for country and Aboriginal women. This is currently obstructed by the law in South Australia.

The residency requirement means that people from interstate locations such as Broken Hill, Alice Springs, Mildura or Darwin who usually access specialist health services in Adelaide and those from overseas such as international students who have not been in South Australia for 2 months cannot access abortion services in this state.

Women who present for a termination when they are past 20 weeks of pregnancy are a small minority of all those who seek an abortion. The current law regarding the upper limit of pregnancy after which a person can no longer have an abortion puts unnecessary pressure on their decision-making and can obstruct their access to care. Although clause 8 of section 82A of the CLCA specifies that 28 weeks is the upper limit, advice from SA Health to abortion providing services in recent years has meant than an abortion is only available up to 23 weeks and 6 days. This upper limit not only restricts women's access to appropriate health care but also compromises the care that health professionals can give. It can mean that decisions about the pregnancy must be made in haste and without all necessary diagnostic information, conditions that severely compromise decision making based on informed consent and the delivery of best care.

South Australia's current laws relating to abortion are outdated and no longer fit for purpose. The presence of abortion in our criminal laws has reinforced stigma and shame and obstructs women's access to advances in abortion care.

Because people in all their diversity require abortions, those who already experience stigma can be more seriously affected by abortion stigma.

Delays in accessing treatment due to fear of judgment and delays in diagnosis due to ill-informed assumptions or institutional practices characterise the experiences of those with mental health conditions, disabilities, non-normative sexualities and gender identities and more.

saaac supports the decriminalisation of abortion law as set out herein to give women better or greater reproductive control and the right to autonomy over their bodies.

saaac submits that abortion should be a woman's decision, affordable to all, and accessible regardless of location. Abortion should be provided by appropriately trained health professionals utilising the most up to date, evidence-based methods suited to the particular woman's circumstances. Abortion should be regulated like other health care, not by criminal law.

To achieve this, *saaac* submits the following reforms are necessary:

1. Removing all references to abortion from the criminal law by repeal of Divisions 17 and 18 of the *Criminal Law Consolidation Act 1935* (SA) (**CLCA**); and
2. The establishment of safe access zones of 150m to protect women and health care workers at premises where abortion care is provided;

These reforms would enable abortions to be provided on the informed consent of the woman and in the most appropriate location by appropriately trained health professionals in accordance with World Health Organisation (**WHO**) recommendations. Further these reforms would enable best practice abortion care to incorporate technological advances and be guided by medical evidence.

saaac does not support the enactment of any new criminal offences specifically referencing or related to abortion. *saaac* does not support the enactment of any specific legislated regulation in relation to abortion at all, with the exception of the introduction of safe access zones.

Law reform for best practice abortion care

saaac submits that best practice abortion care is delivered when abortion at any stage of the pregnancy is treated as a medical procedure.

Despite its outdated and restrictive laws, South Australia has excellent specialised abortion services in metropolitan Adelaide which have been described by interstate counterparts as the gold standard model for abortion service delivery.

South Australia is in a unique position compared to other Australian jurisdictions which have decriminalised. We have the experience of nearly fifty years of abortion service delivery in a legislatively regulated context from which to learn. We are behind the national trend to decriminalise abortion but unlike the process of decriminalisation in ACT, Victoria, Tasmania, the NT and Queensland, we move to do so from a position of very good publicly provided services which lead the country in terms of equity of access to quality service provision (notwithstanding the problems outlined above). Because of this experience and community expectation South Australia should undertake law reform which delivers best practice abortion care now and in the future. It is critical that reform of abortion law in South Australia is 'future proofed' and does not create restrictive or prescriptive laws that would become outdated or stop technological and medical advances from delivering best practice abortion care. Legislative treatment of abortion as a health care procedure like any other will achieve this and provide safe, effective and efficient provision now and for the future.

saaac is supported by a large number of medical and community organisations and peak bodies including, but not limited to:

Aboriginal Health Council of SA
ALP Women's Network
Australian Clinical Psychology Association
Australian Greens SA
Australian Medical Students' Association
Australian Nursing and Midwifery Federation (SA Branch)
Australian Women's Health Network
Australian Psychological Society (SA Branch)
Australian Society for Psychosocial Obstetrics and Gynaecology
Business and Professional Women Adelaide
Children by Choice
Coalition of Women's Domestic Violence Services Inc
Emily's List SA
Family Planning Alliance Australia
Finders University Student Association
Human Rights Law Centre
Marie Stopes Australia
National Association of Abortion and Pregnancy Options Counsellors
National Council for Single Mothers and their Children
Public Health Association of Australia (SA Branch)
Reproductive Choice Australia
South Australian Council of Social Service
South Australian Rainbow Advocacy Alliance
Union of Australian Women
SA Unions Women's Standing Committee
SA Unions
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
SHINE SA
Support After Fetal Diagnosis of Abnormality SA
The Tabbot Foundation
Women's Electoral Lobby
Working Women's Centre SA
Women's International League for Peace and Freedom (SA Branch)
Women's International League for Peace and Freedom (SA Branch)
Women's Lawyers Association South Australia
Working Women's Centre SA
YWCA Adelaide

RESPONSE TO CONSULTATION QUESTIONS

saaac makes the following submissions in response to the consultation questions published by SALRI on 2 April 2019.

Role of the Criminal Law: Questions 1 – 4

In response to **questions 1**, **2, 3** and **4**, *saaac* submits that no aspect of abortion care should be criminalised. *saaac* does not support the enactment of any new criminal offences specifically referencing or related to abortion. No woman should ever be criminally responsible for the termination of her own pregnancy.

Criminalisation of abortion reinforces stigma and is directly linked to medical practitioners being reticent to provide abortion services for fear of prosecution and imprisonment. In addition, criminalisation of abortion procedures increases the risk of reluctance to seek medical assistance.

saaac respects women's rights to make decisions about their own health care and their own bodies. Criminalising health procedures that are accessed only by women and those with female sexual organs discriminates against them on the basis of sex or gender, and infringes their human rights.

saaac submits that abortion should be treated as a medical procedure and regulated according to the normal standards and practices that govern all other health services, which include specific clinical guidelines for each area of care.

saaac does *not* support the enactment of any new criminal offences for abortions not performed by an appropriate health practitioner. *saaac* submits that sufficient safeguards against medical procedures being performed by unqualified persons exist under the law currently.

All health procedures, practices and services are closely controlled and regulated by government, industry and professional bodies, and breaches are dealt with seriously. In this way, existing health law, regulations, codes of practice, clinical protocols and institutional policies and procedures provide a comprehensive regulatory framework that protects patients, promotes good quality and safety in health care and ensures accountability. There are more than 20 health statutes in South Australia, and nearly 70 Commonwealth statutes, covering virtually every aspect of health, aged and disability care and public health.[1]

Assault that results in pregnancy loss

It is important that assaults targeting the fetus, or are reckless as to harming the fetus, be appropriately punished. Assault that results in the loss of a pregnancy or damage to a fetus is an offence under the CLCA, section 24 (serious harm) and section 23 (harm). Harm is defined as any *"physical or mental harm (whether temporary or permanent)"* and assault causing harm carries a potential imprisonment penalty of 5 – 13 years. Victorian legislation addressed concern that these assaults may not be appropriately punished when reforming their abortion law by explicitly changing the *Crimes Act 1958* (Vic) to include the destruction of the fetus in the definition of serious injury; as NSW had previously done.[2]

[1] For example, see: *Health Care Act 2008*; Medical Practitioner Code of Conduct; Perinatal Practice Guidelines; Hospitals' own codes of conduct and procedures; *Consent to Medical Treatment and Palliative Care Act 1995*; *Therapeutic Goods Act 1989* (Cth); Good Medical Practice: A Code of Conduct for Doctors in Australia; *Health Practitioner Regulation National Law (South Australia) Act 2010*.

[2] Rankin M J, 2013 *The Offence of Child Destruction: Issues for Medical Abortion, Sydney Law Review* 35(1), pp1–26.

Who should be permitted to assist in performing terminations: Question 5

In response to **question 5**, *saaac* submits that health practitioners, registered under the Health Practitioner Regulation Law, including but not only medical practitioners, be permitted to authorise or perform, or assist in performing abortions in South Australia. This should be on the basis of their accredited scope of practice as it is for the provision all other health care procedures.

Expanding provision by registered health practitioners other than doctors is a safe and cost-effective solution to the barriers to access caused by lack of providers, a particular access issue in non-metropolitan settings.[3] The WHO provides guidelines for practice to support the development of local practice.[4]

The scope of practice for nurse practitioners, midwives and Aboriginal Health Care Practitioners can be safely expanded to include provision of abortions but as a future health workforce is unknown, *saaac* submits that there should not be legislative constraints limiting flexibility in determining the appropriate providers. Government and the community place their confidence in the regulatory processes of the Australian Health Practitioner Regulation Agency to ensure safe health care provision. Abortion provision should be no different.

[3] Doran F, Nancarrow S. *Barriers and facilitators of access to first trimester abortion services for women in the developed work: a systematic review*, *Journal of Family Planning and Reproductive Health Care*, Vol 41, 170-180. Accessed at: https://srh.bmj.com/content/41/3/170.info

[4] For example: World Health Organisation Guidelines https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf?sequence=1; Barnard S, Kim C, Park Min H, Ngo Thoai D. *Doctors or mid-level providers for abortion. Cochrane Database of Systematic Review* 2015 (7):CD011242. Accessed at: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011242.pub2/full.

Gestational limits and grounds for termination of pregnancy: Questions 6 - 11

In response to **questions 6, 7** and **8**, *saaac* submits that regulatory specification related to stage of pregnancy is unhelpful in the delivery of best care. It produces outcomes that are contrary to women's best interests and is an unnecessary hindrance to the provision of evidence-based best care by health practitioners. *saaac* does *not* support any mandatorily regulated gestational limits in relation to the provision of abortion. *saaac* supports women being able to access abortion on request at any stage of pregnancy.

The great majority of abortions in South Australia are performed in the first trimester (<14 weeks) – 90% in 2016. In that year 2.8% of all abortions were performed at 20 weeks or more. Half of these abortions were performed for reasons of fetal abnormality, and the remaining half for reasons of maternal and mental health, including some for reasons of specific medical conditions but most in this half for reasons of mental health. As explained above, these are performed only up to 23 weeks and 6 days.

The factors that lead women to make the decision to seek to end their pregnancy at 20 weeks or later are often distressing and traumatic. It can be presumed that women who seek an abortion for reasons of fetal abnormality make this decision about a pregnancy that was wanted. Some diagnostic tests cannot be made until after 20 weeks, some need further investigation to produce a conclusive result. In some cases, system failure leads to late diagnosis of problems – for example, poor access to health care for women in rural, regional and remote areas leads to delayed access to tests. Some women, and their doctors, will not recognise their pregnancy until 20 weeks or later, due to youth, or irregular menstrual bleeding or menopausal symptoms. While relatively rare, some women will seek an abortion at 20 weeks or later due to illness or injury, or diagnosis of a serious condition like cancer or unanticipated deterioration in an existing health condition.

Women who seek abortions at 20 weeks or later on the grounds of their mental health will most often be women whose control over their own life circumstances is severely limited. This includes women who experience reproductive coercion, a recognised form of domestic violence, who may have been prevented from seeking an abortion earlier, who have serious drug and alcohol issues, or serious mental health conditions, or who are homeless and/or otherwise isolated from medical and institutional supports in general, or who experience the unanticipated loss of a partner. There are a small group of women seeking an abortion at 20 weeks or later who are given misinformation, sometimes intentionally, about access to abortion. These life circumstances are far from consistent with the idea that women who seek abortions after the first trimester have 'needlessly' delayed the timing of their decision or their access to appropriate health care. In these circumstances mandatorily regulated gestational limits in relation to the provision of abortion are contrary to women's best interests.

In these diverse and nearly always difficult contexts mandated gestational limits put pressure on the decision-making process of the woman, couple or family whose lives are at the centre of the matter. When a pregnancy is diagnosed late, or tests indicate fetal abnormality only at the end of the second trimester, she may have to decide the fate of her pregnancy, and so her own future and that of her family, in a very short space of time. In this context mandated gestational limits also put pressure on health care providers whose obligation to provide best care, in the form of conclusive diagnosis or supportive women-centred counselling, is compromised by a regulatory regime that forecloses options for reasons other than the patient's informed consent. When mandated gestational limits mean that a woman's options will shortly cease, or that her health care providers' actions will become impossible, a woman may choose an abortion when further tests or access to counselling or simply more time would lead her to decide to continue the pregnancy. This was the case of a friend relayed by the Honourable Tammy Franks MLC in her speech to

parliament on 27 February this year.[5] At 21 weeks of her pregnancy Sandy and her partner Rob had received a diagnosis that their baby had a severe heart malformation which was incompatible with life. They were advised by doctors to consider an abortion. These doctors realised that Sandy's decision should not be rushed but she had only ten days before an abortion would be prohibited. But a week later, only two days before the date when they would have to decide, further tests provided better information and it became clear that the baby would have a challenging but manageable heart condition and Sandy and Rob chose to continue her pregnancy.

The status of the fetus can and will be considered in women's decision-making and the willingness of health care providers to perform abortions but this is a matter for which there are no clear clinical or ethical parameters. There are diverse views about the status of the fetus in relation to the woman in whose body it is located. Where the status of the fetus depends on a definition of its viability, among other concerns, this can be hard to determine. The degree to which viability can be measured does not necessarily take into account the length of life to be expected outside the woman's body, or the quality of life, or the meaning of being unwanted by the woman who carries the fetus. For some people the determination of the status and viability of the fetus will be a matter of faith or principle, for others a matter of scientific definition, for some it will be a subjective definition of the woman/couple/family involved, for some a complex mix of all of these. In this dense space where different views quite rightly exist and can be equally respected, the institution of mandatory gestational limits does not promote ethical or patient-centred care.

[5]Parliament of South Australia, Hansard, Statutes Amendments (Abortion Law Reform) Bill Second Readings Speech accessed at: http://hansardpublic.parliament.sa.gov.au/Pages/HansardResult.aspx#/docid/HANSARD-10-26013

saaac anticipates that if and when abortion is decriminalised in South Australia existing Department of Health and Wellbeing policies will be revised and standards and guidance for health care practitioners will reflect a new legal environment so that health care professionals will be able to provide care for women who need abortions that is consistent with contemporary clinical evidence and ethical integrity. This will include guidelines for later gestation abortions.

In response to **questions 9 and 10**, *saaac* does *not* support specifying ground(s) for 'a lawful termination of pregnancy', or the distinction of lawful from unlawful terminations or any associated criminal offences as set out above.
saaac submits that the decision to have an abortion should be made by the pregnant person and provided in consultation with a suitably qualified health practitioner. Requiring certain preconditions to be met in order to have 'a lawful termination' is the effect of the current law. For the reasons outlined above, this unreasonably and unnecessarily limits individuals' access to health care.

In response to **question 11,** *saaac* submits that there should be no mandated considerations for abortion at any stage of pregnancy. *saaac* restates its submissions in relation to question 9 above.

Consultation by the medical practitioner: Questions 12 – 14

In response to **questions 12, 13** and **14**, *saaac* submits that the stipulation in our current laws (made nearly 50 years ago) which require a woman to consult two (2) doctors is completely out of step with the principles of informed consent for adults as legislated for the provision of all other medical procedures in South Australia.[6] This provision demeans women's decision-making authority and creates significant barriers and additional loss of privacy for South Australian women living in regional and rural areas.

[6] *Consent to Medical Treatment and Palliative Care Act 1995 (SA).*

saaac submits that there should be *no* requirement to consult another health practitioner, unless it is deemed necessary as part of the woman's health assessment i.e when or if the woman's medical or psychosocial condition warrants further investigation or support. A women's informed consent should be obtained by her primary health practitioner before that practitioner makes any such referral. She should then be referred to the most appropriate expert health practitioner, as occurs with any health condition. When there is no contraindication to proceeding with the abortion, the woman should not be referred to another health practitioner under any circumstances.

Autonomy is a basic human right in health care. The current stipulation for two doctors can cause delays and additional costs for women and certainly for the health system. It is not consistent with women's human rights and should not be a feature of any future legislation.

Conscientious objection: Questions 15 - 17

In response to **questions 15, 16** and **17**, *saaac* submits that provisions regarding conscientious objection are already made for health professionals in their codes of conduct. These codes recognise that situations can arise where the values or beliefs of a practitioners are so opposed to the needs of their patient that the health professional has a moral conflict. This situation places both the health professional and the patient at risk. Therefore professional codes of conduct provide clear instruction as to the responsibilities to patients. For example: the Australian Medical Association's (AMA) 2019 Conscientious Objection Position Statement (**the AMA Position Statement**. This statement provides clear direction to doctors with a conscientious objection for referral to a medical practitioner that will support the woman's decision for an abortion.[7]

[7] AMA Position Paper 'Conscientious Objection' 2019 dated 27 March 2019, accessed at: https://ama.com.au/position-statement/conscientious-objection-2019. See also the statement of the Australian Nursing and Midwifery Federation http://anmf.org.au/documents/policies/P_Conscientious_Objection.pdf.

saaac endorses the AMA Position Statement as providing clear direction and accountability to support women's right to safe and timely abortion care. *saaac* does *not* support any new laws with reference to abortion and conscientious objection, but rather extensive efforts to ensure that both the community and health professionals are aware of these requirements.

The AMA Position Statement at section 1.5 states:

> *"A doctor's refusal to provide, or participate in, a treatment or procedure based on a conscientious objection directly affects patients. Doctors have an ethical obligation to minimise disruption to patient care and must never use a conscientious objection to intentionally impede patients' access to care"*

The AMA Position Statement further sets out at part 2.3 what a doctor with a conscientious objection should do namely:

- *"inform the patient of their objection, preferably in advance or as soon as practicable;*
- *inform the patient that they have the right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right;*
- *take whatever steps are necessary to ensure the patient's access to care is not impeded;*
- *continue to treat the patient with dignity and respect, even if the doctor objects to the treatment or procedure the patient is seeking;*
- *continue to provide other care to the patient, if they wish;*
- *refrain from expressing their own personal beliefs to the patient in a way that may cause them distress;*

- *inform their employer, or prospective employer, of their conscientious objection and discuss with their employer how they can practice in accordance with their beliefs without compromising patient care or placing a burden on their colleagues."*

In reference to abortion the AMA Statement at part 2.4 states:

> "*The impact of a delay in treatment, and whether it might constitute a significant impediment, should be considered by a doctor if they conscientiously object, and is determined by the clinical context, and the urgency of the specific treatment or procedure. For example, termination of pregnancy services are time critical whereas other services require less urgency (such as IVF services).*"

Counselling: Question 18

In response to **question 18**, *saaac* does *not* support any proposals for compulsory counselling or mandatory waiting periods for women accessing abortion. No other Australian jurisdiction has imposed counselling as part of decriminalisation of abortion. Counselling was not imposed on women as part of the 1969 law reform in South Australia and it should not be imposed now.

saaac supports contemporary evidence based counselling practices and clinical services. *saaac* supports Australians having self-determined access to non-judgemental, comprehensive, evidence based counselling and support that places the woman as the expert in their own life.

The practice standards and ethical guidelines of social work, counselling and psychological registration bodies in Australia support the general principles of client self-determination, self-efficacy and client rights to autonomy over their decisions; these registration bodies include the Australian Association of Social Workers (AASW), the Australian Psychological Association (APA), the Psychotherapy and

Counselling Federation of Australia (PACFA) and the Australian Counselling Association (ACA). These principles are also identified and evidenced by the World Health Organisation, Australian Medical Association(AMA), Royal Australian New Zealand College Obstetricians Gynaecologists (RANZCONG), United Kingdom's Royal College Obstetrics and Gynaecologists (RCOG), Academy of Royal Medical Colleges Medicine (AORMC), and the American Psychological Association (APA).[8] Multiple studies of women's decision-making in pregnancy confirm that the overwhelming majority of women requesting abortion services are confident and firm in their decision. Evidence shows the majority of women report emotional wellness after an abortion.[9] Counselling should not be mandatory but instead women should be advised of services available so they can make an informed choice regarding whether or not they access counselling. A 2013 peer-reviewed qualitative study concluded that requiring women to undergo counselling would:

> *"delay the process and for most women would be an unnecessary burden, whilst also diverting resources from those women who require counselling".*[10]

It should be noted that an informed consent is different to counselling. Informed consent supports people to understand health care procedures and any risks or side effects related to the procedure.

[8] For example see: RANZCOG, *Position statement on Abortion* March 2005, revised March 2019. https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Abortion-(C-Gyn-17)Review-March-2019.pdf?ext=.pdf; Australian Medical Association: *Position statement on ethical issues in reproductive medicine* (2013). https://ama.com.au/position-statement/ethical-issues-reproductive-medicine-2013 See also: Australian Medical Association. *Access to reproductive medicine should be free from political or religious interference*, media release, 4 December, 2013 Australian Medical Association, Canberra. https://ama.com.au/media/access-reproductive-medicine-should-be-free-political-or-religious-interference; Gold, R & Nash, E. (2007). *State abortion counselling policies and the fundamental principles of informed consent* Guttmacher Institute.https://www.guttmacher.org/about/gpr/2007/11/state-abortion-counseling-policies-and-fundamental-principles-informed-consent.

[9] Foster, DG et al, (2015) *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*. Retrieved from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0128832#sec014

[10] Brown, S. (2013) *Is counselling necessary? Making the decision to have an abortion. A qualitative interview study.* The European Journal of Contraception and Reproductive Health Care, 18: 44-48. Retrieved from http://www.tandfonline.com/doi/abs/10.3109/13625187.2012.750290?journalCode=iejc20#preview *See also Baron, C., Cameron, S. & Johnstone, A. (2015). Do women seeking termination of pregnancy need pre-abortion counseling? Journal of Family Planning & Reproductive Health Care, 41: 181-185.*

Informed consent ensures that patients have access to the information they need to make the decisions that are theirs to make.[11] Informed consent is already a standard required of all Australian health care services including current abortion services.

Protection of women and service providers and safe access zones: Questions 19 – 24

In response to **question 19, 21** and **23**, *saaac* supports the introduction of 150 metre safe access zones that will cover the area around premises where termination of pregnancy is conducted as legislated in Victoria.[12] We submit that in the zone around such premises it should be an offence to conduct these behaviours in relation to patients and/or staff who are entering or leaving such premises:

- beset, harass, intimidate, interfere with, threaten, hinder, obstruct or impede;
- communicate in relation to abortion in a manner that is able to be seen or heard by a person accessing, or attempting to access, premises at which reproductive health services are provided, and is likely to cause distress or anxiety (this prohibition does not apply to those who work at the abortion clinic);
- impede access to a footpath, road or vehicle without a reasonable excuse within the zone; and
- make or publish a recording of another person entering or leaving such premises without their consent. [13]

[11] Gold, R & Nash, E. (2007**).** *State abortion counselling policies and the fundamental principles of informed consent* Guttmacher Institute. Retrieved from https://www.guttmacher.org/about/gpr/2007/11/state-abortion-counseling-policies-and-fundamental-principles-informed-consent
[12] *Public Health and Wellbeing Amendment (Safe Access) Bill 2015 (VIC)*.
[13] These prohibitions follow the safe access zones instituted in Victoria by the *Public Health and Wellbeing Amendment (Safe Access) Act 2015 (VIC).*

In response to **questions 20** and **22**, *saaac* submits that these zones should be automatically established and that the prohibition of behaviours should apply at all times, not confined to periods of operation. [14]

Anti-abortion protests at the entrance and adjacent to the Pregnancy Advisory Centre in Woodville, South Australia are commonplace and cause concern and distress to clients and staff. The introduction of safe access zone legislation in Tasmania, Victoria, the ACT, the NT and Qld and in Canada and various states of the USA demonstrates governments' commitment to ensure citizens' right to provide and access health services without hindrance. South Australia should provide the same protections for our citizens.

The High Court of Australia in *Clubb v Edwards & Anor; Preston v Avery & Anor*[15] in April this year upheld the Victorian legislation[16]. As Nettle J noted at paragraph 258:

> *"women seeking an abortion and those involved in assisting or supporting them are entitled to do so safely, privately and with dignity, without haranguing".*[17]

As the validity of the *Public Health and Wellbeing Amendment (Safe Access) Act* 2015 (VIC) has been tested and upheld in the High Court of Australia, South Australia can adopt this legislation in its current form.

In response to **question 24**, *saaac* refers to our responses to question 19, 21 and 23 as set out above.

[14] *Public Health and Wellbeing Amendment (Safe Access) Act* 2015 (VIC).
[15] [2019] HCA 11.
[16] Above n 14.
[17] Above n 15, 84, [258].

Collection of data about termination of pregnancy: Question 25

In response to **question 25**, *saaac* submits that data about abortions in South Australia should not be reportable as it is currently. In relation to any other medical procedure the collection of data, particularly when the data is to be reported on, requires application to and granting of permission from the hospitals ethics committee. The collection of data that currently occurs in South Australia is a gross invasion of women's privacy and should cease.

saaac notes that the form COR 19 is currently required by regulation to be completed by the doctor performing an abortion and signed by them and a second doctor who has also examined the woman. The COR 19 documents personal detail not required for any other health service and includes specific details of the abortion care and treatment provided. Data from the COR 19 forms the basis of reports released by the Pregnancy Outcomes Unit annually and tabled in the South Australian Parliament. *saaac* supports the removal of this regulation and reporting requirements.

saaac submits that data collection about abortions should be treated the same as any other health procedure. National health and medical research guidelines should inform the process. Research ethics require that the purpose for data collection should be clear and justifiable and that the results are used to improve health care. The annual tabling in Parliament of the abortion data has never resulted in a discussion to improve services for women but provided a media opportunity to report on the surveillance of women's reproductive decisions.

Rural and regional access: Questions 26 - 28

In response to **question 26**, *saaac* does *not* support differing laws based on a woman's location. *saaac* supports all women being able to access high quality abortion in South Australia. To improve access for rural women, including Aboriginal women and women from interstate or overseas, *saaac* strongly supports the removal of:

a. the requirement that only medical practitioners can perform abortions;
b. any requirement for residency for women to access abortion services in South Australia;
c. the requirement for an abortion to be provided in a prescribed hospital; and
d. the requirement for women to see two (2) doctors.

In response to **question 27**, *saaac* supports all women being able to use telehealth or other electronic services to consult with medical and/or health practitioners.

In response to **question 28**, *saaac* supports abortion services being provided by telemedicine and/or locally by appropriately trained health care professionals in primary health care settings. This would mean women could choose to have a medical abortion at home or in their closest regional centre and only need to travel to Adelaide for abortion procedures requiring more specialised care.

Incidental

In response to **question 29**, *saaac* supports the removal of any requirement for residency for women to access abortion services in South Australia.

In response to **question 30** and **31**, *saaac* make the following suggestions.

Remove the prescribed hospital requirement

saaac strongly submits that the requirement for abortions to take place in a prescribed hospital be removed. Service delineation models which provide guidance to hospitals and health practitioners already create a framework for the management of abortion services in South Australia. There is no necessity for this to be a legal requirement.

Removal of child destruction clause

As stated above, *saaac* supports the full repeal of Division 17 and 18 of the CLCA.

The interpretation of section 82A of the CLCA and its relationship to the 'born alive rule' have given rise to Departmental concern and consequent service limitations to a 23 week and 6 day gestation limit for abortion in SA.

Service providers have advised women that the opinion of Crown Law is that even procedures meeting the requirements of Clause 1 may be criminal if the pregnancy is 'capable of being born alive'. Hence, services are not offered beyond 24 weeks gestation. Gestation becomes the determining factor rather than the health of the woman.

The 2008 Victorian Law Reform Commission Report, strongly recommended removal of all references to child destruction from abortion laws.[18] The Victorian parliament heeded this advice in 2008 when they repealed the sections of their criminal code relating to abortion.[19]

[18] Victorian Law Reform Commission, *Law of Abortion – Final Report* dated 1 January 2008, accessed at: http://www.lawreform.vic.gov.au/sites/default/files/VLRC_Abortion_Report.pdf
[19] *Abortion Law Reform Act 2008* (VIC).

Early Medication Abortion Medicare Item Number

One of the most significant challenges to medical practitioners fulfilling their role in supporting women's access to abortion relates to Medicare. The Medicare Benefits Schedule (MBS) does not have an item number specific to early medication abortion. Medication abortion requires a long consultation to adequately support and give detailed information to the woman. Without an item number that recognises this, the provision of medication abortion is uneconomic and to date there have been very few regional General Practitioners registered as prescribers. This is a matter before the current MBS review. *saaac* calls for the addition of a Medicare item specific to EMA

Therapeutic Goods Administration

In 2012 the TGA gave mifepristone, the key pharmaceutical drug in EMA, a full license but only on stringent conditions that are not applied to any other drug. This singling out of mifepristone stigmatises the women for whom it is prescribed and dissuades doctors from registering to use the drug. Removing the unnecessary restrictions that currently apply to mifepristone will give it the status of any other drug and will enable it to be made available in ways that are most suitable in providing care in diverse locations. This could include prescription by nurse practitioners. Like the Medicare item for EMA this is a matter outside the purview of South Australian law that nevertheless needs urgent attention.

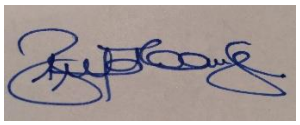
Public funding of abortion services

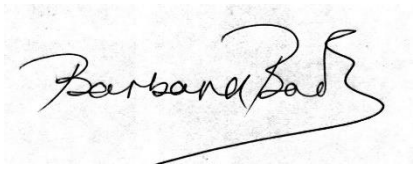
The most important component of the provision of abortion care in South Australia is the commitment to maintain abortion services as publicly funded health services of high quality provided by the expert workforce which has been built here in the past two decades.

We refer to our Fact Sheets which further set out our position in relation to each issue detailed in this submission and are available at: https://saabortionactioncoalition.com/fact-sheets/.

We thank you for the opportunity to provide submissions in relation to this matter. If you would like to discuss any aspect of this submission, please contact *saaac* at saabortionactioncoalition@gmail.com

Yours sincerely,





Ms Brigid Coombe and Dr Barbara Baird
On behalf of *saaac*